Change-Focused Youth Work

The Critical Ingredients of Positive Behavior Change

The basic mission of working with challenging adolescents is to induce positive behavior change. This mission has two levels. First, agency and court personnel work to secure the compliance of adolescents with the rules and requirements of the law and of their respective programs. This first level generally focuses on promoting lawful behavior, consistent attendance at school, family stability, and abstinence from illicit drugs and alcohol. Progressive, more ambitious agency staff strive for a second level of change. Their programs move beyond compliance to seek sustained and autonomous behavior change, facilitated by empowerment and personal "growth," but they do not always receive appropriate support.

Nationally there is public debate on the relative effectiveness of punitive, supervisory, and rehabilitative approaches in modifying delinquent behavior. Public policy has increasingly focused on punishment and monitoring of young offenders, at the expense of treatment. At the same time as this debate and policy shift were occurring, the American Psychological Association (APA) supported a research initiative that assembled the world's leading outcome researchers to review 40 years of psychotherapy outcomes and detail the subsequent implications for direct practice. The initial findings of this research offer relief and encouragement to practitioners of remedial work with challenging adolescents: treatment *is* effective in helping human problems. As the authors of the study, Mark Hubble, Barry Duncan, and Scott Miller, observe in the introduction to their anthology on the effective catalysts of positive behavior change: "Study after study, meta-analysis, and scholarly reviews have legitimized psychologically-based or informed interventions. Regarding at least its general efficacy, few believe that therapy needs to be put to the test any longer."[1]

Ted Asay and Michael Lambert, commenting on previous studies, report, "These reviews leave little doubt. Therapy is effective. Treated patients fare much better than the untreated."[2] Asay and Lambert cite additional findings about therapy that encourage the rehabilitative efforts of adolescent work; data suggest that the road to improvement is not long. After as few as eight to ten sessions, 50 percent of clients showed clinically significant change; 75 percent of clients significantly improved with six months of weekly treatment.[3]

Nevertheless, treatment and rehabilitation efforts are under close scrutiny and scorned by many. Gordon Bazemore and Mark Umbreit, developers of the restorative justice model, explain this scorn: "[I]t is difficult to convince most citizens that juvenile justice treatment programs provide anything other than benefits to offenders (e.g., services, recreational activities) while asking them for little or nothing in return."[4]

The debate has in fact been worthwhile in the development of treatment approaches. As Robert Coates reports, "The debate has had its impact upon practice, forcing practitioners to be even more thoughtful in developing intervention strategies…. The debate about the value of rehabilitation has had considerable positive effects on rehabilitation efforts. More attention is being directed at how caseworkers and others can have positive impact on the client and on the client's social network."[5]

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This article focuses on improving the effectiveness of the therapeutic approach in inducing positive behavior change in youth. It discusses new information gained from an extensive meta-analysis that reviewed 40 years of therapy outcome studies. This important research sought to identify the ingredients of positive behavior change. The study shows that, although treatment has been found effective, no single approach or theory among the more than 400 recognized therapy models has proved to be reliably better than any other. Regardless of many claims made, there are no clear "winners." The research postulates that the effective aspects of treatment are transtheoretical—that is, that any model's effectiveness is due to factors that are common to all therapies. The article discusses these "four common factors"—client factors, relationship factors, hope and expectancy, and model and technique.

In applying this information to work with adolescents, the article points to research-informed strategies—including the strength-based approach—that can translate some of

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therapy's complex practices into commonsensical and usable methods for educators, community youth staff, and juvenile court personnel. The goal of the article is to increase the use of the therapeutic approach by all who participate in adolescent work. ■

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Although the APA research examined psychotherapy outcomes, its findings also are critically important to the treatment initiatives of remedial youth work. Regarding this research, John J. Murphy, a proponent of strength-based strategies in the field of education, states: "[T]he empirical evidence … has profound implications for the manner in which practitioners approach clients of any age and in any setting."[6]

COMMON FACTORS

Having concluded that treatment is effective, the APA study made a second finding that is at least equally significant: None of the numerous treatment models studied has proven to be reliably better than any other.[7] Barry Duncan and Scott Miller report: "Despite the fortunes spent on weekend workshops selling the latest fashion, the competition among the more than 250 therapeutic schools amounts to little more than the competition among aspirin, Advil, and Tylenol. All of them relieve pain and work better than no treatment at all. None stands head and shoulders above the rest."[8] This conclusion has been repeatedly upheld in subsequent studies.[9]

If no theory or model can claim that it is better than the others, then what accounts for the overall efficacy of treatment? Researchers, including Michael Lambert and Mark Hubble, sifted back through four decades of outcome data to postulate that the beneficial effects of treatment largely result from processes *shared* by the various models and their recommended techniques.[10] Simply put, similarities rather than differences in the various models seem to be responsible for change. Each of the varied treatment models aids change by accessing certain common factors that, when present, have curative powers. Lambert concluded from extensive research data that there were four of these common factors:[11]

- Client factors—the client's preexisting assets and challenges
- Relationship factors—the connection between client and staff
- Hope and expectancy—the client's expectation that therapeutic work will lead to positive change
- Model/technique—staff procedures, techniques, and beliefs

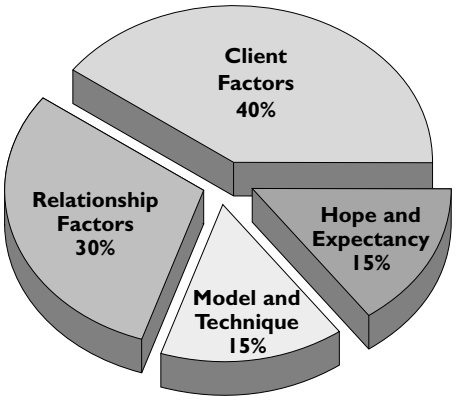
These factors that raise the effectiveness of treatment are *transtheoretical*—that is, all of the various treatment theories and approaches recognize their importance to some degree. Without intentionally focusing on them, all therapies seem to be more effective when they promote these common factors in their own unique ways.

Hubble, Duncan, and Miller speak to this important research finding:

> In 1992, Brigham Young University's Michael Lambert proposed four therapeutic factors … as the principal elements accounting for improvement in clients. Although not derived from strict statistical analysis, he wrote that they embody what empirical studies suggest about psychotherapy outcome. Lambert added that the research base for this interpretation for the factors was extensive; spanned decades; dealt with a large number of adult disorders and a variety of research designs, including naturalistic observations, epidemiological studies, comparative clinical trials, and experimental analogues.[12]

Hubble, Duncan, and Miller also drew upon Lambert's earlier work that rated some factors as more influential in changing behavior than others and ascribed a weighting scale to them. Lambert then ranked and prioritized the common factors according to their amount of influence on positive behavior change. The figure on page 61 depicts the four factors and their percentage contribution to positive change (100 percent represents total positive behavior change).

The Four Common Factors in Positive Behavior Change



SOURCE: M. J. Lambert, *Psychotherapy Outcome Research: Implications for Integrative and Eclectic Therapists, in* HANDBOOK OF PSYCHOTHERAPY INTEGRATION (John C. Norcross & Marvin R. Goldfried eds., Basic Books 1992).

CLIENT FACTORS

Client factors—not what youth and their families receive from staff, but what they possess as they enter the doors of our agencies—are the largest contributor to behavior change (40 percent). Client factors are both internal (optimism, skills, interests, social proclivities, aspirations, past success) and external (a helpful uncle, employment, membership in a faith community). Client factors also include fortuitous events that are controlled by neither the agency nor the youth—an abusing boyfriend moving out and away from the family, a chance school experience instilling renewed interest, a lesson "hitting home" as, for example, when a close friend or peer is seriously harmed by illicit drug use.

In other words, client factors include what youth bring to treatment programs and, just as important, what influences their lives outside the programs. This coin of behavior change is two-sided: one side involves the youth's preexisting abilities, while the other side includes the youth's involvement and participation in agency programming.

Involvement and participation are difficult to encourage. The difficulties lie both in building trust and finding effective ways to encourage adolescents to participate and in persuading staff to build interest and program appeal by breaking from the norm of dictating behavior and allowing youth increased choice and autonomy.

Many treatment programs are not individualized (regardless of their claims), nor do they offer true choices in programming. Furthermore, staff often resist youth input. The views and opinions of adolescents can be markedly different from those of adults; consequently, adults may be resistant to seeking input from teens or to integrating a teen's ideas about "what works" in his or her own treatment or, more broadly, about revisions in programming. It's important for staff to recognize that acknowledging and accepting the beliefs and positions of adolescents is not the same as agreeing with or acquiescing in them.

Such an approach affirms the youth's role in his or her treatment. Indeed, the common-factors research confirmed just this point, that the youth and his or her family, not the staff or providers, make treatment work. This does not mean that program structure or staff efforts are useless. It does, however, suggest that the instruction in remedial interventions offered by universities and training institutes may not be worthy of the robust attention we give them. Duncan and Miller advise: "The data points to the inevitable conclusion that the 'engine' of change is the client. The implication is that perhaps we should spend our years more wisely gaining experience [in] ways to employ the client in the process of change."[13]

The Strengths Model

The strength-based model of youth work draws primarily upon client factors as a foundation for treatment, though it incorporates all four common factors to some degree. Recent efforts have applied this approach to juvenile delinquency and juvenile drug courts.[14] Juvenile court workers have favored a strength-based approach because it uncovers and makes use of adolescents' preexisting abilities.[15] It is drawn from numerous positive models of potential, optimism, and possibility, including the strengths perspective,[16] resilience,[17] optimism,[18] hardiness,[19] asset-building,[20] empowerment,[21] motivational interviewing,[22] and solution-focused approaches.[23] The goal of strength-based practice is to activate an individual's sense of responsibility for his or her actions, thereby altering his or her delinquent behavior. This practice approach does so by applying the science of positive behavior change. Interest and efforts are aimed at *initiating* positive movements, beginning the "first steps" necessary to change the trajectory of an individual young person's life. The approach is not so much a collection of techniques to apply *on* someone as it is the efforts or goals we would strive to achieve *with* another. It focuses more on what the youth has rather than what he or she does not have. It considers the successes of youth and families rather than what they have failed at. The approach works to resolve presenting problems but does so through a focus on potential rather than pathology.

The strengths approach also encourages a balanced view of the individual's weaknesses and strengths and of efforts to raise motivation—necessary components for building solutions to presenting problems. Many are drawn to strength-based work because it not only boosts the resolution of presenting problems but it also nurtures what is best about an individual. Promoting the good life for an individual involves more than removing what is wrong. Martin Seligman, advocating a revival of a strength-based approach in psychology, calls on us to "learn how to build the qualities that help individuals and communities, not just to endure and survive, but also to flourish."[24] The strength-based model, because it focuses on client factors, facilitates this process.

RELATIONSHIP FACTORS

Relationship factors make up about 30 percent of the contribution to change. *Relationship* means the strength of the alliance that develops between youth and staff. Relationship factors include perceived empathy, acceptance, warmth, trust, and self-expression.

Perceived Empathy

Communication studies consistently report that verbal communication is prone to error; the listener does not always receive the message in full.[25] Parts of the intended message are either not adequately articulated by the speaker or not correctly understood by the listener. A dialogue between two people resembles listening to a radio that crackles from weak reception: even if one listens closely, much of the transmission will be garbled or missing.

Perceived empathy involves youths' belief that they are listened to and understood. Relationships develop as staff become committed to understanding their clients and make consistent efforts toward "filling in the gaps" of communication. An important technique for improving communication is "reflective listening," in which the staff member constantly checks the accuracy of what he or she believes the youth has said. My experience in training youth staff is that most personnel, regardless of whether they have previously been trained in reflective listening, seldom, if ever, use this technique. It is simple to understand but tough to use consistently and correctly.

Evidence also shows that "accurate empathy" is a condition of behavior change. William Miller and Stephen Rollnick state: "Accurate empathy involves skillful reflective listening that clarifies and amplifies the client's own experiencing and meaning, without imposing the therapist's own material. Accurate empathy has been found to promote therapeutic change in general and recovery from addictive behaviors in particular."[26]

Compliance can occur without the adolescent feeling understood, *but real change cannot.*

Perceived empathy is a term that corrects a previous bias in research. Most outcome studies measured empathy and the strength of the staff-client alliance through counselor (adult) reports. But in fact it is the youth-participant's assessment of the alliance that matters more. As Karen Tallman and Arthur Bohart report, "[f]indings abound that the client's perceptions of the relationship or alliance, more so than the counselor's, correlate more highly with therapeutic outcome."[27] Further research by Alexandra Bachelor found that the client's perception of the alliance is a stronger predictor of outcome than the counselor's view.[28]

The tendency to privilege staff evaluations over the adolescent's perceptions is rampant in agency youth work. For example, once when I was providing onsite technical assistance to an established juvenile drug court, I had a chance encounter with a group of juvenile probationers who were milling outside the court building awaiting their weekly progress review hearings. I introduced myself and began an impromptu conversation, eventually asking them to offer their personal evaluations of their drug court program. Their responses were both forthcoming and enthusiastic. Encouraged, I brought this information to the next staff meeting, only to find that the program staff members immediately dismissed all this important information because of its source.

Acceptance

Acceptance relates to the extent that any treatment program fits into the family's and adolescent's worldview and beliefs. Alan Kazdin found that the client's ability to accept a particular procedure is a major determinant of its use and ultimate success.[29]

More recent studies found a greater acceptance of treatment and better compliance with interventions when rationales were congruent with clients' perceptions of themselves, the target problems, and the clients' ideas for changing their lives.[30]

An acid test for any youth program lies in the answer to the question, To what extent are interventions predetermined? That is, are adolescents turned into passive recipients of prepackaged programming, or is programming flexible enough that it can be customized to the individual? Progressive youth programs make an effort to instill participation and inclusion of youth. In workshops on strength-based programming, many staff are surprised to learn that there is more leeway to alter and adapt programming than they first believed. The results of this effort can be remarkable. As John Murphy notes, "The notion of acceptability reflects good common sense: people tend to do what makes sense to them and what

they believe will work. It is hardly profound to suggest that the best way to determine what is appealing and feasible for people is to ask them."[31]

It is in this "asking" that profound differences in efficacy are realized. Solution-focused therapists Ben Furman and Tapani Ahola report that the relationship is developed and the alliance strengthened as youth and their families are allowed to have a say in problem definition and goal setting and in deciding what methods or tasks will be used to reach those goals.[32]

There are extenuating circumstances to consider when one allows youth participation at this advanced level. In the mandated arena of some agency treatment programs, because of court referrals to them, participation is not "voluntary" (at least not in the same manner and context as outpatient therapy or counseling). These types of programs may impose a goal of "abstinence from alcohol and other drugs" on an adolescent. This goal will remain in force whether the participant agrees to it or not. However, we can still seek the youth's thoughts and possible ideas for *his or her individualized methods* to achieve that goal. A recent article on strength-based practice argues that programs need to stay close to the youth's and family's definition of the problem (and their own unique methods), as they are the ones who will be asked to make the necessary changes.[33] C.R. Snyder, Scott Michael, and Jennifer Cheavens echo this idea, arguing that staff must listen closely to program youth. If staff do not listen to youth, they may establish therapeutic goals "that are more for the helper than for the helped."[34]

Warmth/Self-Expression

These two conditions for building relationships are intertwined. Extending warmth (attention, concern, and interest) occurs in tandem with allowing a youth self-expression. All staff must understand and embrace a long-held credo from the counseling field: Listening is curative. As Karen Tallman and Arthur Bohart report, "Research strongly suggests that what clients find helpful in therapy has little to do with the techniques that therapists find so important. The most helpful factor [is] having a time and a place to focus on themselves and talk."[35] Others have found that giving traumatized individuals a chance to "tell their story" and engage in "account making" is a pathway to healing. A rather obscure but interesting earlier study showed that paying juvenile delinquents to talk into a tape recorder about their problems and experiences led to meaningful improvements in their behavior, including fewer arrests.[36]

It would be wise for staff to critically examine how they try to build alliances with teenagers, both programmatically and individually, as they interact with them. Duncan and Miller state emphatically, "Clients' favorable ratings of the alliance are the best predictors of success—more predictive than diagnosis, approach, counselor or any other variable."[37] It is worth noting that when both client factors (40 percent) and relationship factors (30 percent) are considered, up to 70 percent of positive behavior change has been accounted for.

HOPE AND EXPECTANCY

The next contributor to change (15 percent) is hope and expectancy—that is, the youth's hope and expectancy that change will occur as a result of receiving community services. In actual practice, staff can encourage hope and expectancy by (1) conveying an attitude of hope without minimizing the problems and pain that accompany the youth's situation; (2) turning the focus of treatment toward the present and future instead of the past; and (3) instilling a sense of empowerment and possibility to counteract the demoralization and passive resignation often found in adolescents who have persistent problems.

Conveying an Attitude of Hope Without Minimizing the Problem

Instilling hope has more complexity than simple encouragement ("You can do it"). Challenging youth need to believe that taking part in programming will improve their situation. Therefore, during the orientation phase of programming, many successful programs provide convincing testimonials of success and program efficacy occurring early in services. Snyder, Michael, and Cheavens relate that the adolescent must sense that the assigned staff member, working in that particular setting, has helped others reach their goals.[38]

Troubled youth and their families often feel "stuck" in problem states. This feeling can be based partly on negative attitudes that allow no escape from problems (i.e., "I *can't* change," "You don't understand—I *have* to hang out with my using buddies"). Strength-based work can instill hope while also acknowledging problems and pain. One strength-based strategy encourages staff to allow the adolescent's problem to coexist with the emerging solution. In many instances within remedial youth work (and throughout the helping professions), there is a mindset to conquer, eliminate, or "kill" the problem. Oftentimes it is helpful and much more expedient to *allow the problem to remain*, to coexist with an emerging solution or healthy behavior that is being developed.

Bill O'Hanlon, a strength-based author and therapist, describes a helpful metaphor that originated in an old vaudeville routine: Two ingratiating waiters approaching the narrow kitchen door repeatedly defer to the other.

"After you," one offers. "No, please, after you," the other replies. Finally, at the same moment, they both decide to act and turn into the door simultaneously, only to wedge their shoulders in the small opening. O'Hanlon advises adult staff to consider the idea of "creating a second door" and allowing conflicting feelings and conditions to coexist.[39] A youth can feel scared and hopeless about his ability to begin abstinence from drugs and yet marshal the confidence to avoid using "just for today." A painfully shy young woman can simultaneously fear the crowded gathering and find the courage to join it. Trying to convince her that "there's no need to be shy" or that "there's nothing to be afraid of" is an uphill climb with dubious results. The conflicting dichotomies of continuing drug use or movements toward sobriety, hesitancy or action, fear or confidence, rather than being framed as an "either/or" choice, can coexist as "both/and." Staff need not eliminate the negative to instill the positive.

This is a not just a meaningless play on words. There is a popular slogan among practitioners of strength-based approaches: "The person is not the problem; the problem is the problem." Strength-based practice takes that idea a step further to assert that the problem is actually the person's *relationship* to the problem.

Becoming Future-Focused

Focusing on past failures usually results in demoralization and resignation. Hope is future-focused. When a youth worker keeps remedial efforts focused on the future, positive outcomes are enhanced.[40] The "problem" is generally found in the present and its roots in the past. The "solution," however, is generally started in the present with efforts aimed at the *future*.

Furman and Ahola report that the *single most useful thing* youth workers can do in the time they spend with troubled adolescents is to get the kids to look ahead and describe what is happening when the problem is envisioned as "solved" or is not considered to be as bad.[41] These European therapists, using strength-based practice, believe that if goals are to be immediately helpful and meaningful to the adolescent and family, they must first be conceived and constructed through visions of a "problem-free future." It is through this looking ahead, a "harnessing" of the future, that goals for present actions (first steps) become known.[42]

An important way to do this is by employing "miracle," or outcome, questions:[43] "What if you go to sleep tonight and a miracle happens and the problems that brought you into this mess are *solved?* But, because you are asleep, you don't know the miracle happened. When you wake up tomorrow, what would you notice as you go about your day that tells you a miracle has happened and things are different?" "What else?" "Imagine, for a moment, that we are now six months or more in the future, after we have worked together and the problems that brought you to our agency have been solved. What will be different in your life, six months from now, that will tell you the problem is solved?" "What else?"

The miracle question is the hallmark of the solution-focused therapy model. A "miracle" in this context is simply the present or future without the problem. It is used to orient the teen and family toward their desired outcome by helping them construct a different future. Helping an adolescent and family establish goals needs to be preceded by an understanding of what they want to happen. When (if) workers find no past successes to build on, they can help the family form a different future by imagining a "miracle." As many youth workers have experienced, it often is difficult to stop a family from "problem talk" and to start the search for solutions. The miracle question is designed to allow the adolescent and family to "put down" the problem and begin to look at what will occur when the problem is not present. If youth are prompted to imagine what a positive future might look like for themselves, they automatically begin to view their present difficulties as transitory. The miracle question is used to identify the youth's goals to reach program completion or other successful criteria.

The miracle question is followed by other questions that shape the evolving description into small, specific behavioral goals: "What will be the smallest sign that this (outcome) is happening?" "When you are no longer (skipping school, breaking the law, etc.), what will you be doing instead?" "What will be the first sign this is happening?" "What do you know about (yourself, your family, your past) that tells you this could happen for you?"

Empowerment and Possibility

Youth programs encourage hope and expectancy when they help adolescents establish goals and act to realize them.

All programs will list large (macro) outcomes or final goals to reach graduation and program completion. Similarly, most remedial plans are established for large issues and long-standing presenting complaints. These plans usually list large problem behaviors to be resolved by a specified date set many months into the future. The problem is that these goals are too big. Instead, day-to-day goal setting should "think small." Goals should be shaped into small steps. According to the "one-week rule" of strength-based practice, a worker and an adolescent should never mutually establish any goal that cannot be reached in the next seven days. Some youth staff go beyond this and use

a "48-hour rule" to make a goal seem more obtainable and to begin behavior change. Short time frames propel "first steps" and start small incremental movements to change. "What can you do after you get home today? by tomorrow afternoon?"

Snyder, Michael, and Cheavens call for interventions to first induce "personal-agency thinking" (e.g., "I *can* do it") and then set mutual, concrete, and obtainable goals to enhance "pathways thinking" (e.g., "here's *how* I do it").[44] Youth agencies would do well to focus staff retreats on these two conditions alone in revising their programs and practices. They could easily spend a day examining where and how their programming enhances agency and pathways thinking and then vigilantly work to increase those conditions. These two conditions help turn the wheel of behavior change.

Psychologists Stephen Ilardi and Edward Craighead found that a large portion of client improvement occurs in the first three to four weeks of treatment. Interestingly, this improvement happens before clients learn the methods or strategies for change that programs stand ready to teach. How could change begin to occur before program direction, teaching, and support can be delivered? These practitioners note that the instillation of hope and expectancy of change is not simply a precondition for change; it *is* change.[45]

MODEL AND TECHNIQUE

Another small contributor to change (15 percent) is assigned to model and technique: staff procedures, techniques, and beliefs, broadly defined as our therapeutic structure and healing rituals. It is humbling to consider that a majority of what universities and institutes teach and expound constitutes one of the smallest contributions to change. Furthermore, programs and techniques are deemed helpful only to the extent that they promote the other common factors.

Nevertheless, the strategies and methods that staff provide to youth are helpful, yet for reasons that are contrary to popular beliefs. Tallman and Bohart explain:

> Clients utilize and tailor what each approach provides to address their problems. Even *if* different techniques have different specific effects, clients take these effects, individualize them to their specific purposes, and use them. … In short, what turns out to be most important is how each client uses the device or method, more than the device or method itself. Clients then are the "magicians" with the special healing powers. [Staff] set the stage and serve as assistants who provide the conditions under which this magic can operate. They do not provide the magic, although they may provide means for mobilizing, channeling, and focusing the client's magic.[46]

It appears that, rather than mediating change directly, techniques used by staff simply activate the natural healing propensity of adolescents. Therefore, it is important to use techniques and develop requirements that facilitate adolescents' progression in this process.

PRACTICE IMPLICATIONS

Certain issues and opportunities arise in revising programs to incorporate strength-based techniques:

1. All youth staff can become change-focused.

Duncan and Miller list several interesting research findings regarding youth staff in direct service roles:[47]

- Andrew Christensen and Neil Jacobson, in their evaluation of counselor effectiveness with clients, found no differences between professionals and paraprofessionals or between more and less experienced therapists.[48]
- Hans Strupp and Suzanne Hadley found that experienced therapists were no more helpful than a group of untrained college professors.[49]
- Jacobson (1995) determined that novice graduate students were more effective at couples' therapy than trained professionals.[50]

It may be surprising to learn that there is little or no difference in effectiveness regardless of training and experience. But these research findings are not so startling or disheartening when one considers that therapy clients (and especially challenging youth) are not passive recipients of clinical expertise but rather active and generative participants in the process of change. Rather than diminishing the importance of experience or credentials of expertise, these findings show that novices and paraprofessionals were somehow better able (in these instances) than experienced professionals to activate the all-important common factors.

Indeed, the findings offer important support to the youth worker. Knowledge of the four common factors penetrates the mystique surrounding "therapy" and illuminates what is truly "therapeutic": positive behavior change. By applying strength-based techniques in their work, more staff members can begin to build the all-important alliance and work to enhance these factors of change with youth and their families. Because of the complexity of many presenting problems, professional therapy and therapeutic treatment will always be needed as adjunct services to youth programs. All professionals

working with adolescents, however, can share those techniques that most effectively induce positive behavior change.

A further issue with becoming changed-focused involves our field's use of mental health diagnoses. Although a diagnosis can be very helpful in providing information and direction for subsequent treatment efforts, Duncan and Miller note one problem that can occur from the rendering of diagnosis. To establish a diagnosis is akin to taking a "snapshot"—a moment-in-time photograph. The problem is that a diagnosis conveys the idea that conditions and behaviors described by the diagnosis are static and constant, even permanent. Strength-based practitioners, however, offer a different—and far more productive—view of the reported problems:

> The magnitude, severity, and frequency of problems are in flux, constantly changing. In this regard, clients will report better and worse days, times free of symptoms, and moments when their problems seem to get the best of them. With or without prompting, they can describe these changes—the ebb and flow of the problem's presence and ascendancy in their daily affairs. From this standpoint, it might be said that change itself is a powerful client factor, affecting the lives of clients before, during, and after (treatment).[51]

Viewing adolescents through a change-focused lens, listening and remaining alert to how they are changing, will help staff recognize their resources and the strengths that are enabling and supporting their progress.[52] Staff can utilize two lines of inquiry to help identify this change. First, questions can be asked about "pretreatment change": "After serious trouble has occurred, many people notice good changes have already started before their first appointment here at this agency. What changes have you noticed in your situation? How is this different from before? How did you get these changes to happen?"[53]

Numerous studies have found that a majority of clients make significant changes in their problem patterns in the time between scheduling their initial appointment and actually entering treatment.[54] Just experiencing some type of start or initiation of change can begin positive movement. Single-subject research recorded similar responses from youth and families newly assigned to my juvenile probation caseload.[55] The important point is that teens and families rarely report these changes spontaneously. Staff must ask questions about these changes or they remain hidden. Many believe that if problems are ignored, they seem to move underground, where they grow and fester and return even stronger. However, when solutions are ignored, they simply fade away unnoticed and, more important, remain *unused*.

The second (and ongoing) line of inquiry identifies change that occurs between appointments or program sessions. When change is found, we need to investigate and amplify: "How did you do this?" "How did you know that would work?" "How did you manage to take this important step to turn things around?" "What does this say about you?" "What would you need to do to keep this going (do this again)?"[56]

When sitting down with a youth during a scheduled report time, many staff will check on issues by using a preformed mental list of questions. These questions become routine: "Were there any violations of program rules this week?" "Have all urine drops been 'clean'?" "Are you in compliance with all program requirements?" "Have you missed any school this past week?" "Have you made all treatment sessions since our last meeting?" These questions are important, but they do not represent a full line of inquiry. When inquiries become routine, they narrow the investigation and bypass many other instances of change. Open-ended questions that search for positive changes should be asked as well.

2. Staff should share the "expert" role with the youth and family.

Adults have become accustomed to guiding and directing youth. Although dispensing advice and setting limits will always have a place in our work, the common-factors research suggests that we must share the lead with them if we want to improve treatment outcomes. Regarding this, several issues are worth noting:

First, as encouraging as this common-factors research is to some, it may be considered threatening to others. Treatment providers or other staff may feel their treatment experience and conventional roles are being called into question. A balance must be struck between the experience and expertise of the counselor and the inclusion of the common factors for effective service delivery. Professional expertise will still be required and in great demand for working with youth, but the strategies that professionals employ will make a big difference in whether they succeed. To be a committed student advocate of change requires a focus not on technique but on the client (i.e., the youth and his or her family) as the common denominator in behavior change. Duncan and Miller address this change of focus: "Models that help the therapist approach the client's goals differently, establish a better match with the client's world view, capitalize on chance events, or utilize environmental supports are likely to prove the most beneficial in resolving a treatment impasse."[57]

Second, staff may be skeptical regarding the exact implications of the common-factors research. For example,

regarding sharing the expert role with challenging youth, staff may think that means they are to acquiesce to stated immature or illogical desires of the youth they work with. In fact, they should not. Any goals stated by the youth that are not interdependent for healthy relationships or that jeopardize health and safety (their own or others') should never be agreed to. Staff can understand without agreeing, however, and they can identify without acquiescing.

Adopting a strength-based approach means reconfiguring our notions of accountability. This second issue—sharing the expert role—involves a review of accountability. Quite simply, current work that favors the views of professional staff over those of the client serves to place too much responsibility for change on the shoulders of staff.

To provide a more thorough explanation of this approach requires first removing a commonly held misconception about strength-based practice. Some critics believe the ultimate goal of strength-based practice is naïvely centered on establishing a positive relationship. They also mistakenly assume that the worker is compelled to give the client Pollyannaish compliments, even in the face of the client's obvious wrongdoing and personal chaos—for example, telling a shoplifter that he is "skillful" or reframing drug dealing as demonstrating "fiscal competence." Although it is true that a positive relationship and compliments have an important place in this approach, they are only important for their capacity to foster behavior change and help people rise above their difficulties. If complimenting clients to ensure a positive relationship is an end to itself, it becomes a narcissistic enterprise. Staff engaged in youth work must challenge adolescents to move beyond their difficulties and help them marshal strengths to meet those challenges.

Compare how both approaches regard accountability. The traditional or current problem-solving approaches entrenched in our field require staff to work hard at understanding the problem, to ascertain who is responsible, how the problem originated, and how it is maintained. Accountability is realized when an adolescent owns up to the wrong. Admission is paramount for the assumption of responsibility. Strength-based practice, on the other hand, does not assume that the ownership of guilt is somehow automatically curative.

Consider an idea forwarded by Don Trent Jacobs from the sports psychology field. When an athlete has performed poorly, the coach spends little time reviewing the error or fixing blame before beginning corrective work. In the sports model, coaches are discouraged from waiting for the athlete to verbally assume responsibility or to assume responsibility passively. Instead, they quickly review the error and focus on encouraging behavior change. Accountability and responsibility for a negative performance are assumed when the athlete begins to change his or her performance.[58]

Insoo Berg, co-founder of the solution-focused therapy model, has reported that the problem-focused model and its emphasis on moving the offender merely to "own up to the guilt" about the past does not hold the offender sufficiently responsible for change in the future. Moreover, too much time and energy are spent determining the causal relationship rather than expecting and demanding changes.[59] The strengths approach with challenging teens holds that accountability is realized through behavior change, not passive admission. From the beginning of contact, there is an expectation that the teen will *do something* about the immediate concern. Strength-based practice is based on the belief that starting "first steps" and initiating action are all-important.

When staff views are favored over those of clients, staff indirectly assume too much responsibility for change, which should rest instead with the client. For this reason, some strength-based agencies have the client, with assistance, write his or her own reports to the court. The client then continues this process by verbally delivering his or her progress summary directly to the judge during the court hearing. Ownership of the treatment plan (and, consequently, empowerment) is thereby increased.

Third, staff may be reluctant to invite more participation—to share the lead with a youth—if they believe their clients are not up to the task. Indeed, some youth may be troubled—and causing trouble to others—yet the vast majority are also capable and competent to begin and sustain needed changes. Dennis Saleebey states:

> If there are genuinely evil people, beyond grace or hope, it is best not to make that assumption about any individual first. Even if we are to work with someone whose actions are beyond our capacity to understand or accept, we must ask ourselves if they have useful skills and behaviors, even motivations and aspirations that can be tapped in the service of change to a less-destructive way of life.[60]

Regardless of its stated values, the juvenile justice field continues a steady diet of finding, diagnosing, and treating failure and pathology. But if practitioners believe that adolescents and family members have strengths, practitioners can then look for and find them to use in their work with their clients. Research cited by Anthony Maluccio found that workers consistently underestimated client strengths and had more negative perceptions of clients and their ability to change than the clients had of themselves.[61] Strength-based work asks workers to forgo this pessimism

and allow an optimistic view. Larry Brendtro and Arlin Ness give a good description of this dichotomy:

> [S]ome might argue that optimism about antisocial youth is itself a thinking error, a Pollyanna illusion that nasty kids are really little cherubs. However, pessimism is seldom useful and often leads to feelings of powerlessness, frustration, and depression. In contrast, optimism feeds a sense of efficacy and motivates coping and adaptive behavior, even in the face of difficult odds.[62]

Forty years of motivational research have shown that an optimistic view pays off: if you expect that change will occur with your clients, your expectation of change will influence their behavior.[63] The worker's belief in the client's ability to change can be a significant determinant of treatment outcome. Indeed, Norman Cousins found that helping efforts are more effective when the worker believes in the client's capabilities and believes that the client can surmount the obstacles to positive behavior.[64] Believing in the client is all-important—it is the axis around which this model turns.

The reverse can also be true. Staff can approach an adolescent with negative expectations, expecting very little if not the worst. One on-site agency evaluation, which included a review of the orientation materials distributed to all prospective youth and families beginning the referral process, found 12 sanctions listed for breaking program rules and only 5 incentives for successful participation. The staff obviously expected that participants would break the rules and communicated that expectation to incoming youth. In fact, this was not the staff's real intent; they revised their materials to incorporate a more equal ratio of incentives and sanctions.

3. Treatment should not simply fix what is broken—it should nurture what is best.

When we incorporate the common-factors research and allow greater participation by the youth and family, they become catalysts for greater gains. Programs need to look beyond the reduction of delinquent behavior to facilitate aspirations, vocational interests, and hobbies *as identified by the youth* or through vocational assessments. Adolescent programs can provide new learning opportunities for youth, helping them find interest, fun, and peer camaraderie without illegal behavior and illicit drug use. Adjunct mentor programs, developed specifically for assisting youth programming, offer tremendous support along these lines.

Strength-based mentoring programs are now being developed along the lines of the trade guilds that operated in Europe in the Middle Ages, in which the youth entered into an apprenticeship that was mutually beneficial to both master and apprentice. A current example of such a relationship might be the matching of a youth with computer interests to an adult who works with computers professionally. The key is matching the adult to the youth, giving consideration to the youth's vocational interests or life's passions. This change in mentoring model is occurring because many current mentoring relationships are inherently awkward—they end up not making sense to either the teen or the adult. Little thought is given to the suitability of a particular match; only the benefit to the youth of spending time with a responsible adult is considered. But because this arrangement is imposed on the youth, its impact on his or her life is inherently limited. In our drive to establish positive adult role-modeling relationships, we have paired teens to adults without a shared rationale that identifies a reciprocity of interests and benefits. A reciprocal mentoring model based on apprenticeship, on the other hand, can lead to relationships that are both natural and *mutually* rewarding.

Gordon Bazemore, Laura Burney Nissen, and Mike Dooley caution that "treatment programs" or remedial services are only one component of an asset-building strategy for challenging adolescents. These authors call on us to raise our sights to increase positive relationships and opportunities for adolescents. It is imperative that opportunities be developed in the youth's own community. Youth programs should consider developing opportunities where a youth participant can

> actively *practice and demonstrate skills* in a way that strengthens a community connection.… [T]he best context for such learning is one in which there is mutual commitment to a common task and, through this task, the opportunity for developing effective ties. The best historical examples are the classic apprenticeship models in craft and trade occupations, the master-student relationship in the arts, and the extended family business—all of which provided natural ties between young and old and a clear transition to adulthood."[65]

4. There should be a greater concentration on building a therapeutic alliance between staff and youth.

Two issues are crucial to building alliances with youth:

The alliance must be formed quickly. This article has explained how influential the staff-youth alliance proves to be in inducing positive behavior change. The common-factors research also indicates, however, that staff *must work fast* to build the alliance. Paul Mohl and others point out that the impact of establishing the alliance *early in treatment*, generally by the fourth or fifth meeting, is critical for treatment outcome.[66]

Many programs begin with intensive orientation. One example is "Jump Start" in the Santa Clara County, California, juvenile drug court. In this program, new participants attend intensive orientation sessions to become familiar with program requirements during their first 30 days of participation in the program. These "jump starts" can be very helpful in orienting the new participant to program regulations.

Upon close inspection, however, most intensive orientations are primarily one-sided. They are solely constructed for the youth to come to understand and become acclimated to the program structure, schedule, and requirements. Instead, to establish the alliance between staff and client quickly, orientations should focus more on reciprocity. That is, it is not enough to warmly greet new participants and introduce the staff to them in round-robin fashion. Adult staff must take a corresponding intensive "jump" by making a concerted effort to meet, quickly become familiar with, and even charm the incoming participant. Some may chafe at the recommendation for staff to court and "woo" incoming adolescents, but the research is clear: the youth's perceptions of the alliance determine the outcome of treatment. Skeptics need only consider the largest outcome study ever undertaken, the NIMH Treatment of Depression Collaborative Research Project, which found that improvement was only minimally related to the type of treatment received but was *heavily determined* by the client-rated quality of the relationship.[67] Even if this study could be ignored, approximately one thousand other studies on alliance building report the same finding.[68]

Alliance building is as varied as the client. There is a difference between "easy" and "simple." It is simple to understand how important the alliance is to outcome and to place a majority of our emphasis there. To say that alliance building is *easy* is quite another matter. All youth are different and, because of different personality styles, they will evaluate the conditions of a positive alliance in differing ways. Alexandra Bachelor found that almost half of all clients wanted to be listened to (empathic reflections) and respected, while another 40 percent wanted more "expert" advice from staff to promote direction and allow self-understanding (to "make sense" of issues). A smaller group wanted input and saw the alliance as a 50-50 partnership in which they felt the need to contribute and have as much input as the staff (counselor).[69] Duncan and Miller state: "The degree and intensity of [staff/counselor] input vary and are driven by the client's expectations of our role. Some clients want a lot from us in terms of generating ideas while others prefer to keep us in a sounding board role."[70]

Staff working with adolescents must not only court and woo new participants, but they also need to survey them continually about their perceptions and ratings of the staff-youth alliance. Simply put, you cannot modify or alter your approach to a youth based on his perceptions if you don't know what his perceptions are. Duncan and Miller cite a critical effort that has profound implications for staff-youth interactions: "Influencing the client's perceptions of the alliance represents *the most direct impact we can have on change*."[71]

POSTSCRIPT

This common-factors research has only recently been published. Presently, many in the fields of psychiatry, psychology, and social work are grappling with its findings. Armed with this knowledge, adolescent staffs and community treatment providers can begin to become familiar with the techniques that engage the common factors. All who work with youth will benefit from these empirical findings on the pathways to change.

This article does not impeach current efforts, but rather the belief that staff and providers are the "engine" of change. Researchers have bemoaned the fact that inquiries of treatment outcome over several decades have studied all the wrong elements—the models, techniques, and staff—while ignoring the most important contributor to change: the youth and his or her family. Staff expertise will always be vital and needed, but only if it changes one's focus to guiding the three critical ingredients to motivation—the youth's resources, perceptions, and participation. Youth and family motivation is not static or fixed but dynamic, and it can be *influenced and increased*. Aligning direct practice efforts to influence and increase the common factors can help advance youth along this motivational continuum.

Most articles, whether research-oriented or practice-based, generally end with a call for further research. Although qualitative and quantitative analysis is invaluable to improve our practice methods, research cannot accomplish this mission unless workers first assimilate it. Scholarly articles today end with a call for "more research" so routinely that it has become almost as standard as a de facto signature line. Consider, however, that the four factors common to all successful treatment have been illuminated by literally thousands of research studies. So, without denying the importance of research, this article does not end by urging more. Instead, it encourages all who work with adolescents to stop and review this compelling research. Keeping in mind the necessary continuum of "research, policy, and practice," youth workers should routinely pause to integrate research. Now is that time.

NOTES

1. Mark A. Hubble et al., *Introduction, in* THE HEART AND SOUL OF CHANGE: WHAT WORKS IN THERAPY 1–2 (Mark A. Hubble et al. eds., Am. Psychological Ass'n 1999).

2. Ted P. Asay & Michael J. Lambert, *The Empirical Case for the Common Factors in Therapy: Quantitative Findings, in* THE HEART AND SOUL OF CHANGE, *supra* note 1, at 23, 24.

3. *Id.*

4. Gordon Bazemore & Mark Umbreit, *Balancing the Response to Youth Crime: Prospects for a Restorative Juvenile Justice in the Twenty-First Century, in* JUVENILE JUSTICE: POLICIES, PROGRAMS, AND SERVICES 376 (Albert R. Roberts ed., Nelson-Hall 2d ed. 1998).

5. Robert B. Coates, *The Future of Corrections in Juvenile Justice, in* JUVENILE JUSTICE: POLICIES, PROGRAMS, AND SERVICES, *supra* note 4, at 437, 439–40 (citations omitted).

6. John J. Murphy, *Common Factors of School-Based Change, in* THE HEART AND SOUL OF CHANGE, *supra* note 1, at 382 (emphasis added).

7. BARRY L. DUNCAN & SCOTT D. MILLER, THE HEROIC CLIENT 65 (Jossey-Bass 2000).

8. *Id.*

9. *Id.* (citing studies).

10. *See* THE HEART AND SOUL OF CHANGE, *supra* note 1, *passim;* Michael J. Lambert, *Psychotherapy Outcome Research: Implications for Integrative and Eclectic Therapists, in* HANDBOOK OF PSYCHOTHERAPY INTEGRATION (John C. Norcross & Marvin R. Goldfried eds., Basic Books 1992).

11. SCOTT D. MILLER ET AL., ESCAPE FROM BABEL: TOWARD A UNIFYING LANGUAGE FOR PSYCHOTHERAPY PRACTICE 24 (W.W. Norton & Co. 1997) (citing Lambert, *supra* note 10).

12. Hubble et al., *Introduction, supra* note 1, at 8.

13. DUNCAN & MILLER, *supra* note 7, at 67 (citing Hubble et al., *Introduction, supra* note 1, at 8).

14. Michael D. Clark, *Brief Solution-Focused Work: A Strengths-Based Method for Juvenile Justice Practice,* 47 JUV. & FAM. CT. J. 57 (Winter 1996); Michael D. Clark, *Interviewing for Solutions: Strength-Based Methods,* 59 CORRECTIONS TODAY 33 (Fall 1997) [hereinafter Clark, *Interviewing*]; Michael D. Clark, *The Juvenile Drug Court Judge and Lawyer: Four Common Mistakes in Treating the Drug Court Adolescent,* 51 JUV. & FAM. CT. J. 37 (Fall 2000); Michael D. Clark, *Strength-Based Practice: A New Paradigm,* 59 CORRECTIONS TODAY 201 (Spring 1997) [hereinafter Clark, *New Paradigm*]; Michael Clark, *Strengths-Based Practice: The ABC's of Working With Adolescents Who Don't Want to Work With You,* 62 FED. PROBATION 46 (1998) [hereinafter Clark, *ABC's*].

15. Clark, *ABC's, supra* note 14; Clark, *New Paradigm, supra* note 14.

16. THE STRENGTHS PERSPECTIVE IN SOCIAL WORK PRACTICE (Dennis Saleebey ed., Longman 2d ed. 1997).

17. RISK AND RESILIENCE IN CHILDHOOD: AN ECOLOGICAL PERSPECTIVE (Mark W. Fraser ed., Nat'l Ass'n of Soc. Workers Press 1997); EMMY E. WERNER & RUTH S. SMITH, OVERCOMING THE ODDS (Cornell Univ. Press 1992); STEVEN J. WOLIN & SYBIL WOLIN, THE RESILIENT SELF: HOW SURVIVORS OF TROUBLED FAMILIES RISE ABOVE ADVERSITY (Villard 1993).

18. MARTIN E.P. SELIGMAN, LEARNED OPTIMISM (Knopf 1991).

19. Suzanne C. Kobasa, *Stressful Life Events, Personality, and Health: An Inquiry Into Hardiness,* 37 J. PERSONALITY & SOC. PSYCHOL. 1 (1979).

20. PETER L. BENSON, ALL KIDS ARE OUR KIDS: WHAT COMMUNITIES MUST DO TO RAISE CARING AND RESPONSIBLE CHILDREN AND ADOLESCENTS (Jossey-Bass 1997).

21. EMPOWERMENT IN SOCIAL WORK PRACTICE: A SOURCEBOOK (Lorraine M. Gutierrez et al. eds., Brooks/Cole 1998); JAMES W. LEIGH, COMMUNICATING FOR CULTURAL COMPETENCE (Allyn & Bacon 1998).

22. WILLIAM R. MILLER & STEPHEN ROLLNICK, MOTIVATIONAL INTERVIEWING: PREPARING PEOPLE TO CHANGE ADDICTIVE BEHAVIOR (Guilford Press 1991).

23. INSOO K. BERG, FAMILY-BASED SERVICES: A SOLUTION-FOCUSED APPROACH (W.W. Norton 1994); INSOO K. BERG & SCOTT D. MILLER, WORKING WITH THE PROBLEM DRINKER: A SOLUTION-FOCUSED APPROACH (W.W. Norton 1992); Peter DeJong & Scott D. Miller, *How to Interview for Client Strengths,* 40 SOC. WORK 729 (1995).

24. Martin E.P. Seligman, *Positive Psychology: An Introduction,* 55 AM. PSYCHOL. 5, 13 (Jan. 2000).

25. HARLENE ANDERSON, CONVERSATION, LANGUAGE, AND POSSIBILITIES: A POSTMODERN APPROACH TO THERAPY (Basic Books 1997); CHARLES T. BROWN & PAUL W. KELLER, MONOLOGUE TO DIALOGUE: AN EXPLORATION OF INTERPERSONAL COMMUNICATION (Prentice-Hall 1973).

26. MILLER & ROLLNICK, *supra* note 22, at 5 (citations omitted).

27. Karen Tallman & Arthur C. Bohart, *The Client as a Common Factor: Clients as Self-Healers, in* THE HEART AND SOUL OF CHANGE, *supra* note 1, at 102.

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28. Alexandra Bachelor, *Comparison and Relationship to Outcome of Diverse Dimensions of the Helping Alliance as Seen by Client and Therapist,* 28 PSYCHOTHERAPY 534 (1991).

29. Alan E. Kazdin, *Acceptability of Alternative Treatments for Deviant Child Behavior,* 13 J. APPLIED BEHAV. ANALYSIS 259 (1980).

30. Collie W. Conoley et al., *Enhancing Consultation by Matching the Consultee's Interpretations and Client Beliefs,* 69 J. COUNS. DEV. 546 (1992) (as cited in DUNCAN & MILLER, *supra* note 7, at 73).

31. Murphy, *supra* note 6, at 370.

32. BEN FURMAN & TAPANI AHOLA, SOLUTION TALK: HOSTING THERAPEUTIC CONVERSATIONS (W.W. Norton 1992).

33. Clark, *ABC's*, *supra* note 14.

34. C.R. Snyder et al., *Hope as a Psychotherapeutic Foundation of Common Factors, Placebos, and Expectancies, in* THE HEART AND SOUL OF CHANGE, *supra* note 1, at 191.

35. Tallman & Bohart, *supra* note 27, at 105.

36. *Id.* (citations omitted).

37. DUNCAN & MILLER, *supra* note 7, at 57–58.

38. Snyder et al., *supra* note 34, at 182.

39. Conversation with Bill O'Hanlon, strength-based therapist (Oct. 12, 2000).

40. Clark, *ABC's, supra* note 14, describes future-focused questions that help orient both youth and staff to solution building.

41. FURMAN & AHOLA, *supra* note 32.

42. *Id.*

43. BERG & MILLER, *supra* note 23.

44. Snyder et al., *supra* note 34.

45. Stephen S. Ilardi & W. Edward Craighead, *The Role of Nonspecific Factors in Cognitive-Behavior Therapy for Depression,* 1 CLINICAL PSYCHOL. SCI. & PRAC. 138–156 (1994).

46. Tallman & Bohart, *supra* note 27, at 95.

47. DUNCAN & MILLER, *supra* note 7, at 66.

48. Andrew Christensen & Neil S. Jacobson, *Who (or What) Can Do Psychotherapy? The Status and Challenge of Nonprofessional Therapies,* 5 PSYCHOL. SCI. 8 (1994).

49. Hans H. Strupp & Suzanne W. Hadley, *Specific vs. Nonspecific Factors in Psychotherapy: A Controlled Study of Outcome,* 36 ARCHIVES GEN. PSYCHIATRY 1125 (1979).

50. Neil S. Jacobson, *The Overselling of Therapy,* 19 FAM. THERAPY NETWORKER 41 (Mar./Apr 1995).

51. DUNCAN & MILLER, *supra* note 7, at 68.

52. Clark, *Interviewing, supra* note 14; Clark, *New Paradigm, supra* note 14; Michael D. Clark, *Solution-Focused Interviewing: A Strength-Based Method for Juvenile Justice,* 11 J. JUV. JUST. & DETENTION SERVS. 12–18 (1996).

53. Clark, *Interviewing, supra* note 14, at 98. *See also* BERG & MILLER, *supra* note 23.

54. MOSHE TALMON, SINGLE SESSION THERAPY: MAXIMIZING THE EFFECT OF THE FIRST (AND OFTEN ONLY) THERAPEUTIC ENCOUNTER (Jossey-Bass 1990); Bernard L. Bloom, *Focused Single-Session Therapy: Initial Development and Evaluation, in* FORMS OF BRIEF THERAPY (Simon H. Budman ed., Guilford Press 1981); Michelle Wiener-Davis et al., *Building on Pretreatment Change to Construct the Therapeutic Solution: An Exploratory Study,* 13 J. MARITAL & FAM. THERAPY 359 (1987).

55. Michael D. Clark, Pretreatment Improvements From Arrest to Case Assignment (1995) (unpublished data from Ingham County Probate Court—Juvenile Division probation caseload, Lansing, Michigan).

56. Clark, *ABC's, supra* note 14, at 48–49.

57. DUNCAN & MILLER, *supra* note 7, at 59.

58. Don Trent Jacobs, *Mining the Gold,* 4 RECLAIMING CHILD. & YOUTH 39–41 (Issue 2 1995).

59. Conversation with Insoo K. Berg, child psychologist (Oct. 16, 1995).

60. Dennis Saleebey, *The Strengths Perspective: Possibilities and Problems, in* THE STRENGTHS PERSPECTIVE IN SOCIAL WORK PRACTICE, *supra* note 16, at 231, 238.

61. ANTHONY N. MALUCCIO, LEARNING FROM CLIENTS: INTERPERSONAL HELPING AS VIEWED BY CLIENTS AND SOCIAL WORKERS (Free Press 1979).

62. LARRY K. BRENDTRO & ARLIN E. NESS, RE-EDUCATING TROUBLED YOUTH: ENVIRONMENTS FOR TEACHING AND TREATMENTS 3 (Aldine De Gruyter 1983).

63. *See* MILLER & ROLLNICK, *supra* note 22, at 34.

64. NORMAN COUSINS, HEAD FIRST: THE BIOLOGY OF HOPE (E.P. Dutton 1989).

65. Gordon Bazemore et al., *Mobilizing Social Support and Building Relationships: Broadening Correctional and Rehabilitative Agendas,* 4 CORRECTIONS MGMT. Q. 10, 16 (Fall 2000).

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66. Paul C. Mohl et al., *Early Dropouts From Psychotherapy,* 179 J. NERVOUS & MENTAL DISEASE 478 (1991); *see* DUNCAN & MILLER, *supra* note 7, at 73.

67. Sidney J. Blatt et al., *Interpersonal Factors in Brief Treatment of Depression: Further Analyses of the NIMH Treatment of Depression Collaborative Research Program,* 64 J. CONSULTING & CLINICAL PSYCHOL. 162 (1996).

68. *See* THE HEART AND SOUL OF CHANGE, *supra* note 1.

69. Alexandra Bachelor, *Clients' Perception of the Therapeutic Alliance: A Qualitative Analysis,* 42 J. COUNS. PSYCHOL. 323 (1995).

70. DUNCAN & MILLER, *supra* note 7, at 85.

71. *Id.* at 75.